Nebraska Department of Health & Human Services
Regulation and Licensure, Credentialing Division, PO Box 94986
Lincoln NE 68509-4986 (402) 471-4376 Fax (402) 471-1066

ATTESTATION

Section 1: ATTESTATION of Jointly Approved Protocols

(For those APRNs who do not have 2000 hours of supervised practice, a master or doctorate degree, and separate course work of 45 contact hours each at the advanced level in pharmacology, health assessment, and pathophysiology/psychopathology.)
This applies to all new graduates.

APRN Name _____ Physician Name _____

Whereas the above named APRN:

1. Does not have two thousand (2000) hours of supervised practice by a physician as required by Nebr. Rev. Stat. 71-1723.02; or
2. Does not have a Master's or Doctorate degree in nursing; or
3. Cannot demonstrate separate course work in pharmacotherapeutics, advanced health assessment, and pathophysiology or psychopathology to include 45 contact hours of graduate work in each area;

Now therefore, be it resolved hereto that prior to commencing practice:

1. The APRN must have an Integrated Practice Agreement with a collaborating physician provided for in Neb. Rev. Stat. 71-1716.03; and
2. The APRN must furnish proof of jointly approved protocols with a collaborating physician which shall guide the nurse practitioner's practice; and
3. The requirement of proof for jointly approved protocols shall be met by the submission to the Department of Health and Human Services Regulation and Licensure, Credentialing Division this signed and verified ATTESTATION of Jointly Approved Protocols.

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STATE OF _____
COUNTY OF _____

I, _____ being duly sworn say that I am the person referred to in this Attestation of Jointly Approved Protocols as an Advanced Practice Registered Nurse (APRN) in the State of Nebraska; that the above named collaborating physician and I have an Integrated Practice Agreement; that I attest the above named collaborating physician and myself have jointly approved protocols that shall guide my practice; and, that upon request will provide the jointly approved protocols.

Signature APRN _____

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STATE OF _____
COUNTY OF _____

I, _____ being duly sworn say that I am the person referred to in this Attestation of Jointly Approved Protocols as a collaborating physician in the State of Nebraska; that the above named Advanced Practice Registered Nurse (APRN) and I have an Integrated Practice Agreement; that I attest the above named APRN and myself have jointly approved protocols that shall guide the APRN's practice; and, that upon request will provide the jointly approved protocols.

Signature Physician _____